Fee-for-Service Frequently Asked Questions FAQ

Indiana Health Coverage Programs
DXC Technology
Annual Provider Seminar – October 2019

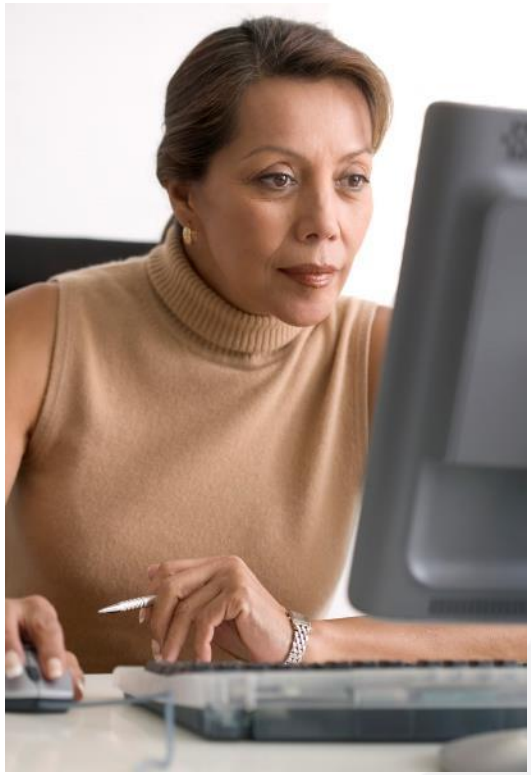
Frequently Asked Questions

FAQ

Community Health Worker (CHW) Billing

How do you bill for CHW services?

- CHW procedure codes:
  - 98960 – *Self-management education & training, face-to-face, 1 patient*
  - 98961 – *Self-management education & training, face-to-face, 2–4 patients*
  - 98962 – *Self-management education & training, face-to-face, 5–8 patients*
- Refer to *BT201826*



Paper Claims

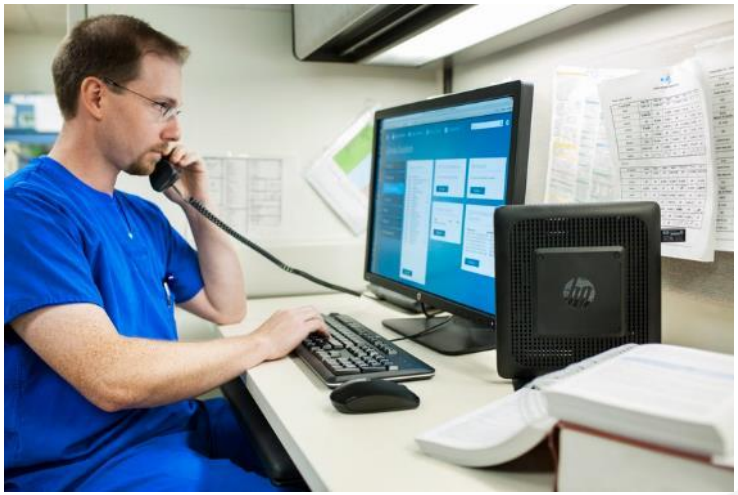
When should you file paper claims?

- Most claims can be filed on the Portal, using the “attachment” and “notes” features
- Portal claims process much quicker than paper, and fewer chances for error
- Paper claims are only required in rare instances:
  - Medicare exhaust claims
  - Claims requiring “special batching”
  - Adjustment claims past the timely filing limit

Third Party Liability (TPL) Updates

How do you update patient insurance information on the Portal?

- Providers can do TPL updates on the Portal via the Secure Correspondence function
- Allow about 20 days for eligibility file to be updated
- Will receive response from Secure Correspondence
- Member should notify Department of Family Resources (DFR)



Down Time

What should we do when the Portal and/or phone lines are down?

- These situations are considered **ULTRA SERIOUS!**
- Always given highest possible priority.
- Usually resolved very quickly.
- So just wait a short while, and then try again.
- Check the IHCP web site for broadcast messages (https://www.in.gov/medicaid/providers/index.html).
- Call Customer Service (1-800-457-4584).

Prize Question!!!!!

The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act.

Who was vice president of the United States in 1965?

Waivers (for Charging Members)

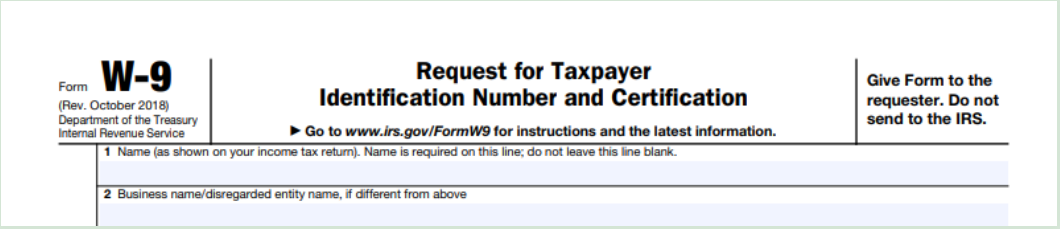
Why does Medicaid not use the Medicare Advanced Beneficiary Notice (ABN)?

- Medicaid does not always follow Medicare guidelines
- Providers should compose their own *waiver* to provide advance notice to a member that a service is noncovered
- The waiver should state specifically what services are not covered and why, and explain that the member will be financially liable
- The waiver is to protect the provider, as it provides documentation that the member was informed in advance of noncoverage and financial liability

W-9

What is the correct way to submit a W-9 form with a provider enrollment application, update, or revalidation?

- Make sure you use the latest version of the W-9 form from the irs.gov web site
- The legal name of the provider and the legal (home office) address on the W-9 must match what is on the enrollment application/update/revalidation **EXACTLY!**
- Mismatching information on the W-9 is the number-one reason enrollment applications and updates are denied



Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

Secondary Claim Filing

When you file secondary claims, when should explanation of benefits (EOB) and third-party liability (TPL) forms be submitted?

- The special TPL form is necessary when you file on paper and Medicaid is the secondary (or tertiary) payer
- Generally, EOBs are required when the primary insurer makes no payment
  - Exception is when Medicare covers the service, but there is no payment because all was applied to deductible/coinsurance/copay
- Additional resources:
  - Study the presentations on secondary billing on the IHCP website, under Provider Education > Archived Workshop Presentations
  - Set up an on-site visit with your field consultant for training
  - Secondary claim filing on the Portal is easy and highly recommended

Portal Eligibility Function

Can the Portal eligibility function show the date that retroactive eligibility was granted? And the start and end date of eligibility?

- Providers should be checking eligibility only for the dates of service (DOS) in question
- Providers should ask the member for a copy of Medicaid approval letter in retroactive eligibility situations
- Use the Claim Notes feature to indicate retroactive eligibility dates, in timely filing limit situations

Prize Question!!!!!

Approximately what percentage of U.S. citizens have some form of Medicaid coverage?

Waiver for Charging Members

What eligibility benefit plans do not require a waiver before you charge the member for a noncovered service?

- Medical Review Team (MRT)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualified Individual (QI)
- Qualified Disabled Working Individual (QWDI)
- Preadmission Screening and Resident Review (PASRR)

System Issues Causing Mass Adjustments

Why does it take so long for claims to be mass adjusted after a system issue is identified?

- Historical claim files have to be searched in certain ways to identify claims that were affected and need adjusted
- These files often contain an enormous amount of claim activity (can be in the millions)
- Various testing methods are used in an attempt to make sure the correct claims are adjusted
- The nature and timing of mass adjustments is always published in a banner page

Claim Suspension

What can you do to make a claim suspend when needed?

- In most cases, a claim submitted on the Portal will suspend when you submit it with an attachment
- “Fatal errors” will cause an immediate denial, without suspension
- Put in a claim note any time you submit an attachment, which will ensure suspension

Treatment Rooms

Some managed care entities (MCE's) pay more than one treatment room per day. Does fee-for-service (FFS) Medicaid pay more than one treatment room?

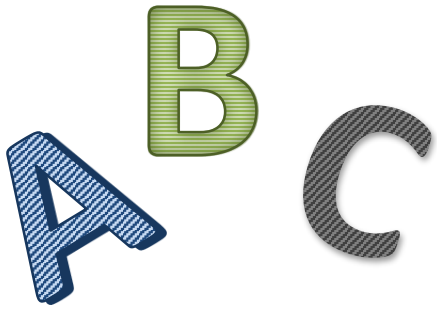
Yes.

- Refer to the *Outpatient Facility Services* provider reference module (*Treatment Room Visits* section)
- Refer to the *Revenue Codes* table on the *Code Sets* page

Prize Question!!!!!

What do these acronyms stand for?

- QMB
- MRT
- PPACA
- *Core*MMIS
- FFS

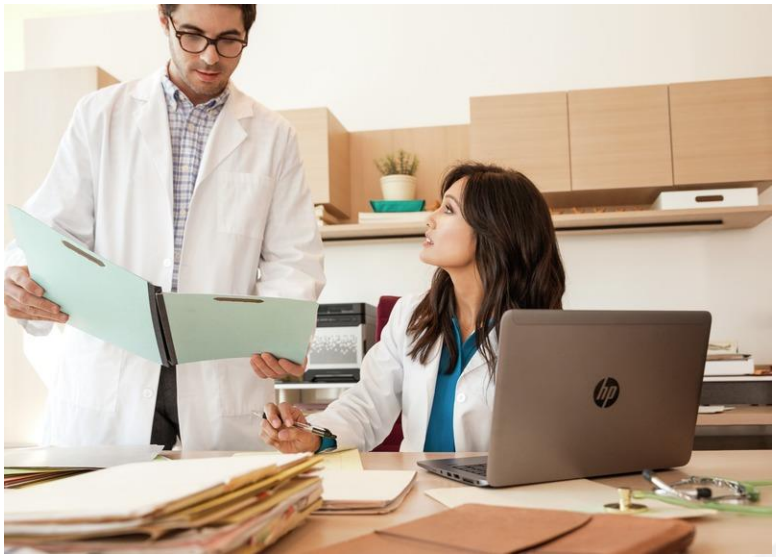


Name all five for a double prize !!!

MCEs and Presumptive Eligibility

Why are MCEs denying all Presumptive Eligibility claims?

- All services provided to members covered under Presumptive Eligibility are fee for service (FFS)
- PE Adult changed from managed care to FFS effective January 1, 2019
- Refer to *BT201862*



Top Denials

Can you provide examples of how to resolve common denials:

- It can be difficult to identify the true denial code because every possible EOB is generated for every eligibility category present for that member
- Example: MRT, PASRR, and Waiver error codes will display when you are not billing those services
- EOB codes are descriptive:
  - **0593** – AT LEAST ONE DETAIL SUBMITTED CONTAINS MEDICARE COB DATA RESULTING IN A REVIEW OF ALL DETAIL COB DATA. PLEASE REVIEW TO ENSURE COB DATA FOR DETAIL IN QUESTION DOES NOT CONTAIN ALL ZEROS OR IS MISSING
  - **2017** – THE MEMBER IS ENROLLED IN THE RISK BASED MANAGED CARE PORTION OF THE HOOSIER HEALTHWISE PROGRAM OR HAS BEEN IDENTIFIED AS A MEMBER OF THE HOOSIER CARE CONNECT PROGRAM. THE MEMBER MUST SEEK CARE FROM THE APPROPRIATE MANAGED CARE ENTITY

Medical Review Team (MRT)

What is the MRT benefit plan?

- When someone does not qualify for Medicaid based on standard criteria, they may qualify for Medicaid due to a disability. The State has a Medical Review Team (MRT) that determines whether or not an individual qualifies for Medicaid due to a disability.
- The only service Medicaid will pay for on someone who has only the MRT benefit plan is a service specifically requested by the MRT to determine whether the person should qualify. So if someone only has MRT, they have no Medicaid coverage (except as described above).
- If a person has MRT and another benefit plan (such as Full Medicaid or Package A), then they have full Medicaid coverage.
- MRT is not technically Medicaid. If a member only has MRT, you can bill the member, without having to notify them in advance or having them sign a waiver.

Prize Question!!!!!

Who were the last five governors of Indiana?

Prior Authorization of Emergency Admissions

Is prior authorization (PA) required for emergency inpatient admissions?

- Prior authorization is not required for emergency inpatient admissions
  - Exception: All psychiatric, rehabilitation, and substance abuse inpatient admissions require PA
- Emergency is indicated by admission types 1−*Emergency*, 4−*Newborn*, and 5−*Trauma*
  - Admission type 2−*Urgent* does **not** indicate emergency

Sterilization Consent Forms

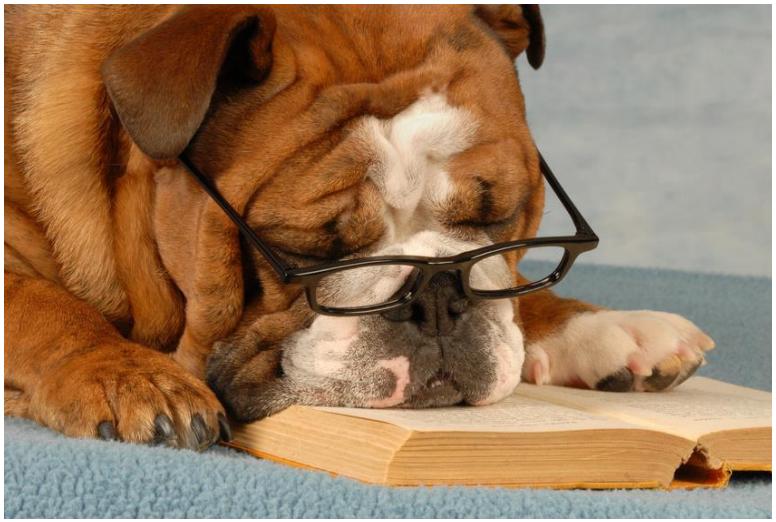
When is it necessary to submit a sterilization consent form?

- The IHCP reimburses for sterilizations only when a valid *Consent for Sterilization* form accompanies all claims connected with the service.
- Exception: A sterilization consent form is not necessary when a provider renders a patient sterile as a result of an illness or injury.
  - The physician must attach a certification to the claim indicating that the sterilization procedure occurred due to an illness or injury when prior acknowledgement was not possible.
- Exception: A sterilization consent form is not required when only a partial sterilization is performed.
  - Providers *must note* "partial sterilization" on the face of the claim form, preferably on the line below the HCPCS procedure code. For electronic claims, a claim note may be used.
- Refer to the *Family Planning Services* provider reference module.

Replacement Eyeglasses

If a member is eligible for a new set of eyeglasses, but their current set of replacement eye glasses are in perfect condition, must the provider provide a new set?

- Not unless medical necessity is met due to change in prescription



Provider Profile Updates

How can provider profile information be updated?

- Many provider profile changes can be made on the Provider Healthcare Portal, via the Provider Maintenance function
- This was a topic at the 2019 Summer provider workshops:
  - Tips and Reminders

Protected Health Information (PHI)

When is it acceptable to include PHI in a nonsecure email?

- ***NEVER!***
  - ***Including in the subject line***

Presumptive Eligibility Adult – Copays

Why are PE Adult copayments not being deducted from provider payments?

- There is currently a change order in process to correct this situation.
- Watch for an upcoming bulletin or banner page.

Medicare Crossover

What is a Medicare crossover?

- Medicare, including Advantage/replacement plans, is the primary payer.
- Medicare covers the service.
  - Medicare pays something, or applies payment to deductible/coinsurance/copayment
- If Medicare does not cover the service, the claim is not considered a crossover.
  - Bill Medicaid as primary
  - Attach Medicare explanation of benefits (EOB)

Rendering Provider Portal Registration

Is it still necessary for rendering providers to register for Portal accounts, as described in BT201931?

- Due to the delay in the development of the centralized enrollment and credentialing process, it is not *critical* for rendering providers to register on the Portal at this time.
- Eventually, it will be necessary for rendering providers to do so.

Prize Question!!!!!

Who are the Secretary of FSSA and the Indiana Medicaid Director?

Prior Authorization

Why is it so difficult to get prior authorization (PA) for home health physical and occupational therapy after surgery?

- Refer to the *Home Health Services* provider reference module for PA requirements.
- Certain home health services do not require PA following a member's discharge from an inpatient hospital stay if a physician orders the services in writing before the member's discharge.

Prize Question!!!!!

What are the three longest rivers in Indiana?

Triple Bonus Question:

What is the fourth longest river in Indiana?

Top Ten FAQ

1. How can someone apply for Medicaid?
2. How can I become a Medicaid provider?
3. How can I update my provider information on file?
4. What codes should I use to bill my claims?
5. How can I determine if someone is enrolled in Medicaid for a particular date of services?
6. How can I determine whether a service is covered?
7. Did you receive my transmission of electronic claims?
8. What is the status of my submitted claim?
9. What testing is needed for approval of trading partner software?
10. What is HIPPA and how does it affect me?

For answers, refer to the *FAQS - Top Ten Questions* page, under the Provider References tab at in.gov/medicaid/providers.

Helpful Tools

Helpful Tools

Provider Relations Consultants

REGION	FIELD CONSULTANT	EMAIL	TELEPHONE	COUNTIES SERVED
1 Illinois Michigan	Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St.Joseph, Starke, Steuben, Whitley Chicago, Watseka Sturgis
2 Illinois	Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware Fountainm Grant, Howard, Hutington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White Danville
3	Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boonem Hamilton, Hendricks, Johnson, Marion, Morgan
4 Kentucky	Ken Guth	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderbirgh, Vermillion, Vigo, Warrick Owensboro
5 Kentucky Ohio	Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne Louisville Cincinnati, Harrison, Hamilton, Oxford
	Judy Green		(317) 488-5026	All other out of state areas not previously listed
Team Lead	Jenny Atkins		(317) 488-5032	

Helpful Tools

IHCP website at in.gov/medicaid/providers:

- *IHCP Provider Reference Modules*
- *Medical Policy Manual*
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal

  *(After logging in to the Portal, click the **Secure Correspondence** link to submit a request)*

Questions

Following this session, please review your schedule for the next session you are registered to attend

Session Survey - Tuesday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1046

Session Survey - Wednesday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1058

Session Survey - Thursday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1059